Nebraska Department of Health and Human Services

Attached Application for Benefits

(Application is available in Spanish-Solicitud esta disponible en español)

The attached application can be used to apply for any of the following programs.

Food Stamp Program (FSP)

The FSP assists households with limited assets and income to buy the food they need for good health. Households qualify for Food Stamp benefits based on available household assets, income and certain expenses. If the household is eligible, Food Stamp benefits are placed on an Electronic Benefits Transfer (EBT) card for the household to buy food.

The FSP follows regulations and rules established by the federal government.

Aid to Dependent Children (ADC)

The ADC Program provides money payments and/or medical coverage to eligible parents and dependent children age 18 or younger who qualify because the family has little or no income. Participation in Employment First may be required.

Employment First (EF) is the name of Nebraska's welfare reform program. The goal of EF is to help families achieve economic self-sufficiency through training, education, and employment preparation. EF is designed to assist families through the transition from welfare to the work force.

Low Income Home Energy Assistance Program (LIHEAP)

The LIHEAP may help an eligible household with some of their winter heating bills, utility shut-offs, empty or low heating fuel tanks, utility deposits, air conditioning, and the repair or replacement of a furnace.

Child Care (CC)

The CC Program assists eligible parents and caretakers in paying for the cost of child care while they work, attend employment-related training or school, or participate in another approved activity.

Based on their income the family may be responsible to pay for a portion of the cost.

Refugee Resettlement Program (RRP)

The RRP may provide financial and medical assistance to persons who are not eligible for other programs to achieve economic self-sufficiency. Assistance may be available to single adults or childless couples in the first 8 months after their arrival in the United States.

Medicaid

Nebraska's Medical Assistance Program (Medicaid) can help pay for certain health care services for eligible families and individuals which include the following:

- Parent(s) with dependent minor children;
- Children under 19 years of age;
- Pregnant women;
- Aged, Blind and Disabled persons.

Assistance to the Aged, Blind or Disabled (AABD)

The AABD Program provides money payments and/or medical coverage to individuals or couples who:

- Are age 65 or older;
- Have been determined to be permanently and totally disabled or permanently and totally blind;
- Have a temporary disability that will last at least 6 months;
- Need help paying their Part B Medicare Premium.

NOTE: Individuals are not eligible for both the "Blue Cross/ Blue Shield" Comprehensive Health Insurance Pool (CHIPs) and Medicaid at the same time.

Kids Connection (KC)

Children under 19 years who are not covered by health insurance may be found eligible for KC, a Medicaid program for qualified uninsured children.

Child Support Enforcement (CSE)

Anyone who has a child and needs help in establishing paternity will receive CSE services. CSE services will also assist in establishing a court order, and/or collecting current or past due child support payments.

Other Services

Other services available to allow an eligible person to remain in their own home:

- Personal Assistance Services
- Chore
- Transportation
- Adult Day Care
- Meals
- Respite

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EA-117 Rev. 1/08 (56084)
(Previous version 11/06 should be used)

Visit our Website at: www.dhhs.ne.gov

- To find more information on the programs offered
- To find an online application that may be printed and completed
- To find an address for your local Nebraska Department of Health and Human Services (DHHS) office

To apply for benefits, take, mail or fax your completed application to a local DHHS office.

Answer all the questions listed on the application. Many questions are "Yes" or "No".
You may be asked to provide more information.

- **You must complete the entire application before we can determine your eligibility.**
- You may turn in an incomplete application with only your name, address, and signature on Page 1. An authorized representative may sign for you. If you turn in an incomplete application, we will contact you.
- For Food Stamps benefits, we will issue your benefits based on the date we receive your application.
- Households eligible for expedited service may receive Food Stamp benefits within 7 days.

Different programs require proof of some or all of the sources listed below:

Household members – birth certificates or proof of identification, age, and family relationships, Social Security Numbers (SSNs), citizenship or immigration status.

Resources – checking and savings accounts, stocks and bonds, certificates of deposits, retirement accounts including IRAs and Keogh Plans, property owned other than the home you live in, automobiles (includes trucks, motorcycles, ATVs, trailers, boats and airplanes).

Income – check stubs from employment (includes jobs left within the last 90 days), ledgers and income tax returns from self-employment including farming; child support or alimony; Social Security income; pension; unemployment benefits; interest or dividends; student income (work study, graduate assistance, fellowships, stipends).

Expenses – House or rent payment, lot rent, utilities, medical expenses including health insurance, child support payments and child care or dependent care payments.

Food Stamp and Medicaid Programs: This application asks you to tell us about the citizenship and immigration status of people in your household. It also asks you to give us Social Security Numbers (SSNs) for everyone in the household. You are not required to provide this information. If some family or household members do not wish to apply for Food Stamp benefits or Medicaid, they do not need to provide their SSN or immigration status. If anyone in your household doesn't have an SSN, we can help them apply for one. Your application will not be delayed. We use SSNs to help us verify information such as income. If people in your household choose not to give us information about their immigration status or SSN, they must still provide us the information needed to determine the eligibility of the other persons in your household. You may withdraw your request for benefits for these persons or you may withdraw your entire application. For further information regarding how SSNs are used, see your information packet.

Child Care: You are not required to give us your Social Security Number (SSN) to receive Child Care Subsidy. If you choose to give us your SSN, we will use it to help us verify information such as income.

DHHS
Nebraska Department of Health and Human Services

Nebraska Department of Health and Human Services
Application for Assistance

1. **Instructions to file an application for benefits:**
Answer the questions and sign this application, then take, mail or fax this application to your local Nebraska Department of Health and Human Services Office (DHHS). This becomes a valid application once you enter your name and address, sign the form and return it to your local DHHS Office. You may have someone help you complete this form, or you may contact your local DHHS office for help. We may have to meet with you in order to process your application.

2. If you need us to provide an interpreter, check here ☐ What language?_____

3. Do you or does anyone in your household need help with any of the following? Please mark all you wish to apply for:

☐ Aid to Dependent Children (ADC)	☐ Medicaid	☐ Transportation
☐ Aid to Aged, Blind & Disabled (AABD)	☐ Kids Connection	☐ Meals
☐ Refugee Resettlement Program (RRP)	☐ Child Care	☐ Adult Day Care
☐ Food Stamp Benefits	☐ Personal Assistance Services	☐ Respite
☐ Energy Assistance for Utilities	☐ Chore	☐ Other_____

4. Do you have a Nebraska Electronic Benefits Transfer (EBT) card for Food Stamp benefits?
☐ Yes ☐ No

4a. If you are applying for Food Stamp benefits, help us determine if you need a face-to-face interview or a telephone interview. Check any boxes that apply:
☐ I am age 60 or older or I am a person with a disability.
☐ I have transportation difficulties.
☐ I care for another household member during regular business hours.
☐ I work or attend school during regular business hours.
☐ Other:_____

5. Applicant information:

Name:_____
First Middle Last

Birth date:_____ Social Security Number*:_____

Address where you live:_____

City:_____ County:_____ State:_____ Zip code:_____

Mailing address (if different from above):_____

City:_____ County:_____ State:_____ Zip code:_____

Telephone number:_____ Message number:_____

Signature:_____ Date:_____

*A Social Security number is not required to apply for Child Care Assistance, Social Services for the Aged and Disabled (SSAD) and Social Services for Children and Families (SSCF).

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MC Name:_____ MC#:_____

Request Date:_____ Mail Date:_____ Received Date:_____

Interview Date:_____ ☐ Face to Face OR ☐ Phone Review Date:_____

Initiating Office:_____ Transferring to office:_____

Application: ☐ New_____ ☐ Recertification_____ ☐ Review_____

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6. Complete this section for yourself and everyone who lives with you, even if they are not applying. If you are residing in a nursing home, boarding home or other group home, list only yourself, your spouse and minor children. Depending on the type of assistance you have requested, immigration status and Social Security Numbers may be verified. Attach another sheet if more space is needed.

Name (List yourself first) Last name, first name	Relationship to you. (If not related write "NR")	Birth date	Age	Sex Male (M) Female (F)	Social Security Number	Is this person a U.S. citizen? Yes	Is this person a U.S. citizen? No	If U.S. citizen, list state where born	Does this person eat with your family? Yes	Does this person eat with your family? No	Is this person disabled? Yes	Is this person disabled? No	Marital status & effective date
	SELF												

7. List any previous names used including maiden name:_____

8. Please mark your living arrangement:

- ☐ Live in a house - rent/own/mortgage
- ☐ Rent an apartment, duplex, triplex
- ☐ Rent a room
- ☐ Board and room situation
- ☐ Adult Family Home
- ☐ Center for Developmentally Disabled
- ☐ Assisted Living
- ☐ Nursing home
- ☐ Drug abuse or alcohol treatment center
- ☐ Battered spouse shelter
- ☐ Group home, foster care, child care institution
- ☐ Other:_____

9. Previous address if you have moved or anyone in your household has moved in the last 30 days:

Address:_____ City:_____ State:_____ Zip code:_____

10. Emergency contact:

Name:_____ Phone number:_____ Relationship:_____

11. Answer Yes or No for each line.

- ☐ Yes ☐ No Do you have an eviction notice?
- ☐ Yes ☐ No Have your utilities been shut off or do you have a shut off notice?
- ☐ Yes ☐ No Are you out of heating fuel (propane, oil)?
- ☐ Yes ☐ No Do you need help with food right now?
- ☐ Yes ☐ No Do you need any other help right now? If yes, tell us what you need in the space below:

_____

12. Are you or is anyone in your household a migrant or seasonal farm worker?

☐ Yes ☐ No If yes, give us the following information:

☐ Yes ☐ No 12a. Did all income for your household stop in the last 30 days?

If yes, last date money received:_____ Amount:_____

☐ Yes ☐ No 12b. Will you or anyone in your household receive income from a new source in the next ten days?

If yes, what date is the money expected to be received?_____ Amount:_____

☐ Yes ☐ No 12c. Was your household previously approved for a delay of required verifications?

If yes, when:_____ Where:_____

13. Are you requesting assistance for anyone in your household who is pregnant?
☐ Yes ☐ No If yes, provide the following information:

Name:_____ Expected Date of Delivery:_____

14. Do you or does anyone in your household applying for or receiving help have a guardian, conservator, or individual acting under power of attorney?
☐ Yes ☐ No If yes, give us the following information:
Name of person with Guardian, Conservator or Power of Attorney:_____

Name of Guardian, Conservator, or Power of Attorney:_____ Phone number:_____

Address:_____ City:_____ State:_____ Zip code:_____

14a. Does Guardian/Conservator receive payment for his/her services?
☐ Yes ☐ No

15. **OPTIONAL**- Indicate the race and ethnic category of the head of household. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure that benefits are distributed without regard to race, color, ethnicity or national origin. If you do not enter any information, the worker will enter an answer.

Race - Select all that apply:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:_____

Ethnic Category - Are you Hispanic or Latino?
☐ Yes ☐ No

16. List all members of your household who are NOT citizens of the United States. Include their immigration status and their alien number:

Name	Immigration status & alien number	Name	Immigration status & alien number
1.		2.	
3.		4.	

17. List all members of your household that are members of a tribe:

Name	Tribe	Name	Tribe
1.		2.	
3.		4.	

18. Did you or anyone in your household receive assistance from another state (for example: cash assistance, medical assistance, or Food Stamp benefits) in the last three months?
☐ Yes ☐ No If yes, give us the following information:

Who	Type of assistance	When (month & year)	Where (state & county)	Caseworker (name & phone number)
1.				
2.				

18a. Do you or does anyone in your household receive Indian Reservation (tribal) commodities?
☐ Yes ☐ No If yes, who:_____ When:_____

19. Answer Yes or No for each line.
Have you or has anyone in your household ever been disqualified in one of the following programs: (Example of disqualification: intentionally provide false information, etc.)?

☐ Yes ☐ No Food Stamp Program (FSP)
☐ Yes ☐ No Aid to Dependent Children (ADC)
☐ Yes ☐ No Child Care (CC)

If yes, give us the following information:

Name of person disqualified	Where did it happen? (county & state)	When did it happen? (month & year)	For how long (6 months 1, 2, or 10 years OR permanently)?
1.			
2.			

20. Answer Yes or No for each line.
Are you or is anyone in your household currently:

☐ Yes ☐ No a. Fleeing to avoid prosecution or custody/confinement after conviction for a felony crime?
☐ Yes ☐ No b. In violation of probation or parole?

If yes, give us the following information:

Who	What	When	Where
1.			State: County:
2.			State: County:

21. Answer Yes or No for each line.
Have you or has anyone in your household:

☐ Yes ☐ No a. Been charged and convicted of a felony (after August 22, 1996) for possession, sale, use, or distribution of a controlled substance? A "controlled substance" is an illegal drug or certain drugs that require a doctor's prescription.
☐ Yes ☐ No b. Been found to have misrepresented identity or residence in order to obtain multiple benefits at the same time?
☐ Yes ☐ No c. Been found guilty of selling Food Stamp benefits of $500.00 or more?
☐ Yes ☐ No d. Been convicted of using and/or receiving Food Stamp benefits in exchange for firearms, ammunition, or explosives?

If yes, give us the following information:

Who	What offense	Date of offense	Where
1.			State: County:
2.			State: County:

22. Designation of **"Head of Household"** for the Food Stamp Program:
If your household has more than one parent, you must tell us which parent should be designated as "Head of Household". In households without children, the head of household must be the person who has the greatest amount of earned income in the previous two months.

The **"Head of Household"** is:_____

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A. RESOURCES

23. Answer Yes or No for each line.
Do you or does anyone in your household have any of the following resources? Include children. This includes resources that your name or any household member's name appears as an owner. If yes, give us the following information:

Type of resources	Answer Yes or No	Amount	Owned by	Account number	Where located
a. Cash	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
b. Checking	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
c. Savings	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
d. Child's account	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
e. Child's account	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
f. Real Estate/Real Property/Farmland	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
g. Trusts	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
h. Life Insurance	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
i. Burial Funds/ Trusts Burial Spaces	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
j. Nursing Home Account	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.
k. ReliaCard Account	☐ Yes ☐ No		1. 2.	1. 2.	1. 2.

24. Answer Yes or No for each line.
Do you or does anyone in your household have any of the following resources? Include children. This includes resources that your name or any household member's name appears as an owner.
If yes, write the value on the line provided:

☐ Yes ☐ No 401K $_____
☐ Yes ☐ No Annuities $_____
☐ Yes ☐ No Certificates of Deposits $_____
☐ Yes ☐ No Credit Union Accounts $_____
☐ Yes ☐ No Crops/Livestock $_____
☐ Yes ☐ No IRA $_____
☐ Yes ☐ No Keogh $_____
☐ Yes ☐ No Machinery $_____
☐ Yes ☐ No Savings Bonds $_____
☐ Yes ☐ No Stocks/Investments $_____
☐ Yes ☐ No Other: _____ $_____

25. Does your name or any household member's name appear on the title of any licensed or unlicensed vehicles (includes cars, trucks, motorcycles, ATVs, boats, RVs, snowmobiles, trailers, aircraft, etc.)? Attach another sheet if more space is needed.

☐ Yes ☐ No If yes, give us the following information:

Owner	Type of vehicle	Model	Year	Value	Amount owed
1.				$	$
2.				$	$
3.				$	$
4.				$	$

26. Have you or has anyone in your household sold, traded or given away anything of substantial value within the past 60 months (five years)? If you are applying for Food Stamp benefits only, list any items sold, traded or given away in the last three months. Attach another sheet if more space is needed.

☐ Yes ☐ No If yes, give us the following information:

Owner	What was sold, traded or given away	When	Value
1.			$
2.			$
3.			$

B. EARNED INCOME

27. Do you or does anyone in your household work? Include children. Work includes employment and self-employment. Self-employment could be farming, odd jobs, providing child care, housekeeping, etc.

☐ Yes ☐ No If yes, give us the following information:

Name of person working	**Employer:** Name, address, telephone **Self-Employment:** Write SE and describe	Monthly gross (before taxes)	Number of hours worked per week	How often is pay received
1.				
2.				
3.				

NOTE: You are allowed to claim certain costs of doing business (expenses) to apply against your self-employment income. These costs can be obtained from tax returns or self-employment ledgers. Your worker will explain which of these documents (tax return or ledgers) you will need to provide to identify the allowable costs of doing business.

28. Do you or does anyone in your household receive tips, bonuses or incentive pay?

☐ Yes ☐ No If yes, give us the following information:

	Name	Amount	How often received
Tips	1. 2.	1. 2.	1. 2.
Bonuses	1. 2.	1. 2.	1. 2.
Incentive Pay	1. 2.	1. 2.	1. 2.

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29. Have you or has anyone in your household left a job or reduced work hours in the last 60 days?
☐ Yes ☐ No If yes, give us the following information:

Name	Employer information	Date of change (month, day, year)
1.	Name: Address:	
2.	Name: Address:	

30. Are you or is anyone in your household on strike?
☐ Yes ☐ No If yes, give us the following information:

Name of person on strike:_____ Date started:_____

C. STUDENT INCOME

31. Answer Yes or No for each line.
Have you or has anyone in your household applied for or are you or is anyone in your household receiving a graduate assistantship, fellowship or stipend?
☐ Yes ☐ No Applied
☐ Yes ☐ No Receiving
If yes, give us the following information:

Who receives the income	Amount	How often received	Period of time income is to cover	Expenses
1.				
2.				

D. OTHER INCOME

32. Answer Yes or No for each line.
Have you or has anyone in your household applied for or are you or is anyone in your household receiving other income that is not from working? Include children.
If yes, give us the following information:

Type of income	Receives	Applied for	Who	Amount	How often received
a. SSI	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
b. Social Security	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
c. Pension/Retirement	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
d. Veterans Benefits	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
e. Cash Assistance Payments	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
f. Workers Compensation	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
g. Unemployment Compensation	☐ Yes ☐ No	☐ Yes ☐ No	1. 2.	1. 2.	1. 2.
h. Child Support/Alimony	☐ Yes ☐ No	☐ Yes ☐ No	State & County	1. 2.	1. 2.
			Court Order #	1. 2.	1. 2.
i. Child Support/Alimony	☐ Yes ☐ No	☐ Yes ☐ No	State & County	1. 2.	1. 2.
			Court Order #	1. 2.	1. 2.

33. Have you or has anyone in your household applied for or are you or is anyone in your household receiving any of the following incomes? Include children.

☐ Yes ☐ No

If yes, give us the following information:

- Write the monthly amount received on the line.
- If anyone has applied to receive these benefits, but does not receive them yet, write "Applied" on the line.
- If left blank, no amount is listed or "Applied" is not written in, this means no one receives nor plans to receive these monies.

Attach another sheet of paper if more space is needed.

$_____ Annuities
$_____ Civil Service
$_____ Claims/Disability
$_____ Contributions
$_____ Farm Income
$_____ Gifts/Money from Relatives or Friends
$_____ Insurance/Accident Settlement
$_____ Interest/Dividend
$_____ Life Estates
$_____ Military Allotment
$_____ Native American Benefits
$_____ Partnerships/Corporations
$_____ Prizes/Awards/Winnings/Lottery
$_____ Railroad Retirement
$_____ Rental Income
$_____ Striker Income
$_____ Trusts/Inheritances
$_____ Other:_____

NOTE: Food Stamp Program: Failure to report or verify an expense will be seen as a statement by your household that you do not want to receive a deduction for the unreported and/or unverified expense.

E. HOUSING & UTILITIES

34. Answer Yes or No for each line. Are you or is anyone in your household billed for the following expenses?
If yes, give us the following information:

Expense	Answer Yes or No	Amount currently billed	Who pays this bill (List names of anyone who helps pay this bill)	How often billed
a. Rent	☐ Yes ☐ No			
b. Mortgage	☐ Yes ☐ No			
c. 2nd Mortgage	☐ Yes ☐ No			
d. Lot rent	☐ Yes ☐ No			
e. Property taxes on home (if not included in mortgage)	☐ Yes ☐ No			
f. Homeowners Insurance (if not included in mortgage)	☐ Yes ☐ No			
g. Condominium/Association fees	☐ Yes ☐ No			
h. Other_____	☐ Yes ☐ No			

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35. If renting, give us the following information:

Name of landlord:_____ Phone number:_____

35a. Is this public/subsidized (Section 8) housing?

☐ Yes ☐ No

36. Do you or does anyone in your household receive a bill for heating and/or cooling (air conditioner) separate from your rent or mortgage payment?

☐ Yes ☐ No If yes, which of the following is your main source of heating and/or cooling?

☐ Electrical/Heat ☐ Electrical/Cool ☐ Kerosene ☐ Natural Gas

☐ Coal ☐ Fuel Oil ☐ Wood & other sources ☐ Propane

Heating Supplier:	**Cooling Supplier:**
Name:	Name:
Address:	Address:
Account Number:	Account Number:

37. If you answered "No" to question #36, are you or is anyone in your household billed for any of the following:
Answer Yes or No for each line.

☐ Yes ☐ No Electricity for other than heating or cooling

☐ Yes ☐ No Natural Gas/Fuel Oil/Kerosene/Propane for other than heating or cooling

☐ Yes ☐ No Maintenance for wells and septic tank

☐ Yes ☐ No Water

☐ Yes ☐ No Sewer

☐ Yes ☐ No Trash/Garbage Collection

☐ Yes ☐ No Telephone

38. Did you or anyone in your household receive help in paying heating and/or cooling bills in the last 12 months?

☐ Yes ☐ No If yes, give us the following information:

Who paid? Low-Income Home Energy Assistance Program (LIHEAP) or someone else?	**Name & address of where you lived when you received this assistance**
1.	
2.	

F. OTHER EXPENSES

39. Are you or is anyone in your household **paying** child support? Attach another sheet of paper if more space is needed.

☐ Yes ☐ No If yes, give us the following information:

Who pays	**Court order#**	**State & county issued**	**Amount ordered**	**Amount being paid**
1.				
2.				
3.				
4.				

40. Are you or is anyone in your household **billed** for Child Care or dependent care?

☐ Yes ☐ No If yes, give us the following information:

Who provides care	**Amount**	**How often billed**
Name: Address:		
Name: Address:		

G. CHILD CARE

41. Do you currently have child care or do you need a child care provider?
☐ Yes ☐ No If yes, what is the reason you have or need child care:_____

42. In order to receive child care assistance, I agree to have my child(ren) receive shots to protect against diseases (such as measles, chicken pox) or infection in accordance with state immunization guidelines.
☐ Yes ☐ No If you marked no, please check the reason below:
☐ a. My religious beliefs do not allow shots; **or**
☐ b. These shots would harm my child's medical condition. (This requires a doctor's statement.)

H. SCHOOL

43. Are you or is anyone in your household attending school, including college?
☐ Yes ☐ No If yes, give us the following information:

Name	School name	School address	Attending full time or part-time	Grade/class attending
1.		Street: City: State:		
2.		Street: City: State:		
3.		Street: City: State:		

44. If attending college or university, are you or is anyone in your household participating in work study?
☐ Yes ☐ No If yes, list names:_____

45. **This question applies only to families with children:** List below all members of your household over 16 years of age and the highest school grade they have completed:

Name	Highest grade completed	Name	Highest grade completed
1.		2.	
3.		4.	

I. MEDICAL

46. Do you or does anyone in your household owe medical bills from the past three months?
☐ Yes ☐ No If yes, give us the following information:

Name	What months	Name	What months
1.		2.	
3.		4.	

NOTE: It is important to provide this information now, as Medicaid may be able to help pay these bills.

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47. Do you or does anyone in your household have medical problems or medical costs due to an accident?
☐ Yes ☐ No If yes, give us the following information:

Person's name:_____ Date of accident:_____

47a. Is there an attorney involved?
☐ Yes ☐ No
If yes, name of attorney:_____ Phone number:_____

47b. Is there an insurance company involved?
☐ Yes ☐ No
If yes, name of company:_____ Phone number:_____

48. Do you or does anyone in your household have Medicare (Social Security)?
☐ Yes ☐ No If yes, give us the following information :

Name	Medicare claim number	Name	Medicare claim number
1.		2.	

49. Are you or is anyone in your household covered by medical insurance? Examples: Medicare supplemental, health, hospitalization, accident or dental insurance. Include policies through work, military, or policies paid for by someone outside your household.
☐ Yes ☐ No If yes, give us the following information for each person and policy:

Name(s) of insured person(s)	Policy holder	Insurance company	Policy/group number	Premium paid
1.		Name: Address: Phone:		
2.		Name: Address: Phone:		

50. If you are disabled or age 60 or older, do you or does anyone in your household who is disabled or age 60 or older, have medical expenses not fully paid by any other source, including health insurance? This may include medications, deductibles, co-pays, co-insurance and travel expenses to or from medical appointments.
☐ Yes ☐ No If yes, give us the following information:

Name	Who is owed or was paid	Amount owed or amount paid
1.	Name: Address: Phone:	
2.	Name: Address: Phone:	

FOR OFFICE USE ONLY

NOTE: **Health Check**: The Nebraska Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a service available to all eligible Medicaid participants age 20 and younger.

51. Does anyone in your household age 20 or younger need a medical or dental examination?

☐ Yes ☐ No If yes, list name(s):_____

J. CHILD SUPPORT INFORMATION

52. For all children age 18 or younger (including any unborn): provide the following information for any child who has a parent not living in your household. Attach another sheet of paper if more space is needed.

Child's name (If unborn, write unborn)	Information for parent not living in your household	This parent's employer information	Does this parent's name appear on the birth certificate?	Did this parent sign a paternity acknowledgement?
1.	Name: SSN: Birthdate: Address: Phone:	Name: Address: Phone:	☐ Yes ☐ No	☐ Yes ☐ No
2.	Name: SSN: Birthdate: Address: Phone:	Name: Address: Phone:	☐ Yes ☐ No	☐ Yes ☐ No
3.	Name: SSN: Birthdate: Address: Phone:	Name: Address: Phone:	☐ Yes ☐ No	☐ Yes ☐ No

OPTIONAL:
Designating Authorized Representatives for Food Stamp Program Only

53. You may choose a person or persons to do the following for you:

a. Apply for Food Stamp benefits on your behalf:

Name:_____ Relationship:_____

Address:_____

City/State/Zip:_____ Phone number:_____

b. Use your Food Stamp benefits to buy food through your Electronic Benefits Transfer (EBT) card:

Name:_____ Relationship:_____

Address:_____

City/State/Zip:_____ Phone number:_____

Voter Registration

54. Any citizen in the State of Nebraska who has met the voter registration requirements and applies for public assistance/ Food Stamp benefits must be provided the opportunity to register to vote.

☐ Yes ☐ No If you are not registered to vote where you live now, would you like to apply to register to vote today?

If you did not check either answer, you will be considered to have decided not to register to vote at this time.

The application form is pages 1 through 16.

You must initial, sign and date on page 16 for this to be considered an application.

Child Support Enforcement (CSE)

Recipients of public assistance and Child Care Subsidy for minor children agree to receive CSE services, and to cooperate with CSE staff in all matters pertaining to paternity determination, location of non-custodial (absent) parents, and establishment, enforcement, and/or modification of a support order. Medicaid recipients, if not receiving other assistance, have the option to notify CSE that they do not want the services that are not related to established paternity and securing medical support.

Exception: Individuals should contact their workers immediately if they believe that cooperation or proceeding to establish or secure support is against the best interest of the child(ren), parent/needy caretaker relative, and/or guardian/conservator for whom support is sought.

Social Security Numbers of the child(ren) may be used for establishment and/or enforcement of medical support.

When ADC cash assistance is paid to an individual or family unit, the State has the right to receive and keep support payments due to any persons listed in the application for assistance. This process, known as an assignment, includes any support owed to the person at the time of application, as well as current and future support that may become due during the period that public assistance is provided. Support collections will be paid out according to State and Federal laws and rules. Any child/spousal/medical support payments received directly by an ADC recipient in the same month as ADC cash assistance must be reported and turned over to the State immediately.

Child Care Assistance

The family is responsible for paying the provider for any unapproved child care. Families responsible for paying a fee for child care services but who fail to pay the fee may have their child care case terminated.

Nebraska Low Income Home Energy Assistance Program (LIHEAP)

When a household receives LIHEAP, they must agree to take full responsibility for paying heating bills if the assistance payment comes directly to the household. If there is an overdue bill or poor payment history, the local Nebraska Department of Health and Human Services (DHHS) office is authorized and may make payment directly to the provider on behalf of the household.

Medicaid

Third Party Liability: Individuals who receive Medical Assistance (Medicaid) assign to the Department of Health and Human Services (DHHS) their right to any medical support or other payment for medical care, agree to cooperate with the DHHS in establishing paternity, and cooperate with the DHHS in obtaining any available third party such as an insurance payment or court settlement. Medicare benefits are not assigned.

Individuals must cooperate with the DHHS in obtaining reimbursement for the cost of medical care and services for any members of the assistance unit. Refusal to cooperate will result in the termination of medical assistance eligibility for that individual. The DHHS will waive the requirement to cooperate if it determines that the individual has good cause for refusing to cooperate. Good cause is a finding by the DHHS that cooperation is against the best interests of the child or against the best interests of the individual because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to the individual or other person.

Medical Records Release: Upon release, any person who has medical records and information or the custody of such records regarding Medicaid recipients must release them to the DHHS.

Medical Reimbursement Agreement: When the DHHS pays for services for a Medicaid recipient, the amount the DHHS has paid to treat the injury or illness must be included in any legal claim made against a third party. If the Medicaid recipient later receives an insurance or court settlement, the DHHS must be notified of the settlement and repaid from the settlement for the medical assistance the DHHS has previously paid.

Medicaid:

- Present proof of your current Medicaid eligibility to medical providers before obtaining services.
- Ask your medical provider or worker about which services are covered.
- Inform your worker and your medical providers of any health insurance coverage you have (including dental coverage.)
- Agree to enroll in employer-based group health insurance if the DHHS determines it is cost effective.
- Agree to comply with managed care requirements.
- Pay the cost of all non-covered medical expenses.

- If you get any bills or statements from providers or collection agencies, you are responsible to tell them right away your coverage is Nebraska Medicaid.

Failure to follow certain conditions may result in your being responsible to pay the bills.

Annuity Requirement: As a condition of receiving medical assistance coverage for long term care services for you or your spouse, the DHHS must become the remainder beneficiary of any annuity under standards prescribed by the U.S. Secretary of Health and Human Services.

Medicaid Estate Recovery Program: Under Federal law (Social Security Act, Titile 19, Sec. 1917 {42 U.S.C. 1396P}) and State law (Nebraska Rev. Stat. 68-919), the Medicaid Estate Recovery Program authorizes the DHHS to make recovery from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program (471 NAC 38-000). For further information or questions about the Medicaid Estate Recovery Programs, you should contact your DHHS worker and request the "Medicaid Estate Recovery" program brochure.

Aid to Dependent Children (ADC) and Child Care Penalty Warning

Individuals who have knowingly provided false information in order to qualify for ADC or Child Care subsidy benefits may be subject to disqualification due to an Intentional Program Violation (IPV). For the ADC Program, only the individual found to have committed the IPV shall be disqualified. For the Child Care subsidy, the individual found to have committed the IPV and his/her family shall be disqualified. The period of disqualification shall be a) For a first violation, up to one year; b) For a second violation, up to two years; c) For a third violation, permanent disqualification. These penalties shall also be imposed if an individual is found by a court to have violated Nebraska Revised Statutes, Sec. 68-1017.

Food Stamp Program Penalty Warning

The information provided on this application is subject to verification by federal, state and local officials. If any is found inaccurate, participation in the Food Stamp Program may be reduced, terminated or denied.

Individuals who have knowingly provided false information may be subject to criminal prosecution. Any member of a household who breaks any of these rules on purpose may be barred from the Food Stamp Program for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. Additionally individuals may be fined up to $250,000, imprisoned for up to 20 years, and subject to prosecution under other applicable federal laws. A court can also bar an individual from the program for an additional 18 months. These penalties apply to food stamp household members as well as to retailers and others.

DO NOT:

- **Give false, incorrect, or incomplete information to obtain or continue to obtain food stamp benefits.**
- **Trade or sell food stamp benefits or Electronic Benefits Transfer (EBT) cards.**
- **Use other people's food stamp benefits or EBT cards unless designated.**
- **Use food stamp benefits to buy ineligible items such as alcoholic drinks or tobacco.**
- **Use food stamp benefits to buy illegal drugs, firearms, ammunition, or explosives.**

Individuals found guilty in federal, state, or local court of the following offenses will be disqualified from participating in the Food Stamp Program:

- **Use of food stamp benefits in the sale of a controlled substance--disqualified for 24 months for the first violation, permanently for the second violation.**
- **Drug felony for sale or distribution of a controlled substance including the intent to sell or manufacture, which was committed and had been convicted after August 22, 1996–permanently disqualified.**
- **Committed and been convicted of a drug felony for possession or use of a controlled substance IF the individual(s) has had three or more convictions for the possession or use, after August 22, 1996. If fewer than three convictions, is the individual(s) currently participating in or has s/he completed a state-licensed or a nationally accredited substance abuse treatment program since the date of the last conviction? If verification is provided of participation in and/or completion of the substance abuse program, the individual(s) may be eligible.**
- **Use of food stamp benefits to purchase firearms, ammunition, and explosives--permanently disqualified.**
- **Misrepresenting residency or identity in order to receive multiple food stamp benefits--disqualified for 10 years.**
- **Trafficking of food stamp benefits of $500 or more--permanently disqualified.**

- **During the time an individual is fleeing to avoid prosecution, custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of the place from which the individual is fleeing, or is violating a condition of federal or state probation or parole, the individual is ineligible to participate in the Food Stamp Program.**

Child Care Subsidy Program

Child care is authorized only for specific and limited purposes. Refer to the "Understanding the Child Care Subsidy Program" document which clearly outlines purposes for using child care and your responsibilities. Child care can only be used for the purposes authorized and as further explained in this document. If you use care for another purpose, you could be required to repay DHHS for unauthorized child care.

Work Registration

For the Food Stamp Program, the signature of the head of household, other adult in the household, or an authorized representative on this application constitutes registering for work of all non-exempt household members.

When this application is signed I agree that

Under penalties of law and/or perjury, I declare I have read this application, including accompanying statements and to the best of my knowledge, the information is true, correct and complete. I understand my responsibilities and agree to fulfill them. I understand I may have to provide proof of what I have said. If written proof is not available, I agree to give the name or organization so that the local office may obtain the necessary proof. I will cooperate fully with state and federal personnel in a Quality Control Review. I certify all persons for whom assistance is being requested are U.S. citizens or are in satisfactory immigration status according to the program(s) or services requested. I authorize the release of the SSNs provided on this application to DHHS to use for the purposes mentioned in your information packet.

Authorization for Release of Information

I authorize the release of information requested by the DHHS. The requested information must be used solely in the administration of public assistance programs and will not be released to any other person or agency outside of the DHHS except as stated under the Medical Records Release. This release of information is in effect while I am an applicant or recipient of public assistance or a financially responsible member and for any later investigations pertaining to my eligibility and receipt of benefits. I understand the DHHS may release information to another agency when services of that agency have been requested or when the objective in obtaining the information is to provide services to me or to any member of the assistance unit.

Receipt of Information Packet

I acknowledge that I received the packet of information that includes my Rights and Responsibilities, Reporting Changes, Fair Hearings, Work Requirements, Medicaid, and the HIPAA Notice.

INITIAL HERE ✍ _____(Initial)

A reproduction of this release is as valid as the original

_____ _____

Signature of Applicant Date Signature of Other Adult Household Member

_____

Printed Name (if applicant signs with a mark)

_____ _____

Signature of Witness (if a mark was used) Signature of Person Who Helped (Authorized Representative/Conservator/Guardian or Power of Attorney)

_____

Worker Conducting Interview

INFORMATION PACKET

Worker Name:_____ Phone Number:_____

YOU HAVE THE RIGHT TO:

- Apply and discuss any action taken on your application or case with your worker or your worker's supervisor.
- Be assisted in the application process by the person of your choice.
- Referral to other private or public agencies.
- See a copy of the program regulations.
- Have an interview in your home, at a mutually agreed upon location, or by telephone in special circumstances.
- Reasonably prompt action on your application for benefits.
- Adequate notice of any action affecting your application or case.
- Have program requirements and benefits fully explained.
- Receive medical assistance (Medicaid) without a separate application if you are eligible for Aid to Dependent Children (ADC), Aid to the Aged Blind and Disabled (AABD), or the Refugee Resettlement Program (RRP).
- Have your information treated confidentially.

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information. You may be subject to criminal penalties under applicable state or federal laws if you do not provide complete and accurate information. You are primarily responsible for providing proof of your household situation, but your worker will assist you in obtaining verification if you cooperate with the application process.
- Apply for and accept any potential benefits or income you may be eligible for if requested to do so by your worker.
- Pay a co-pay for certain medical services if required to do so.
- Pay a fee to your child care provider if required to do so based on your income.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain Medicaid recipients.
- Ask questions if you do not understand something about any program requirements.

FAIR HEARINGS

If you disagree with any action taken by the Nebraska Department of Health and Human Services (DHHS) which affects your benefits, you may request a fair hearing in writing or orally through the local office. You may continue to receive your current level of assistance until a hearing decision is made IF (1) you request a hearing within ten days from the date of the agency notice, and (2) for Food Stamp benefits only, your certification period has not expired. A fair hearing request must be made within 90 days of the action or inaction. You or your representative have the right to examine your case record. At the hearing you may represent yourself or be represented by another person.

CIVIL RIGHTS

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

VOTER REGISTRATION

Please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes. Applying to register or declining to register to vote will not affect the amount of assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

Nebraska Secretary of State
State Capitol Building
Lincoln, Nebraska 68509-4608
Telephone: (402) 471-2554

HOME VISITS

A DHHS worker or contract agency representative:

- May conduct home visits to determine the appropriate types of assistance needed AND/OR
- May contact other people to verify eligibility for assistance.

REPORTING CHANGES FOR AABD, ADC, AND MEDICAID

(This includes Kids Connection and Children's Medical)

Report all changes within ten days to your worker such as:

- Changes in the household, someone moves in or out
- If you move
- New employment
- Termination or change of employment - including job training or other work activities
- Change in the amount of monthly income
- Changes in disability or incapacity
- A change in health insurance
- A change in a resource (not required for Kids Connection or Children's Medical)

REPORTING CHANGES FOR FOOD STAMP BENEFITS

There are three reporting categories in the Food Stamp Program (FSP): Change Reporting (CR), Six-month Reporting (SR), and Transitional Benefits Reporting (TBR). The reporting category to which you will be assigned is determined by your household situation. You will be informed of the reporting category, certification period and reporting requirements on your Notice of Eligibility. If your Food Stamp benefit reporting category changes during the certification period, you will receive another notice with the reporting requirement for the new category. If you have any questions, or need help in understanding your notice or reporting category, contact your worker.

ELECTRONIC BENEFITS TRANSFER (EBT) CARD

Food Stamp benefits are issued on an Electronic Benefits Transfer (EBT) card. If you have lost or misplaced your EBT card, please call 1-877-247-6328 to request a replacement card.

SOCIAL SECURITY NUMBER

The DHHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance is requested as required by the federal Social Security and Food Stamp Acts. Individuals who are not applying for assistance for themselves are not required to have or provide an SSN. If the individual is financially responsible for others in the assistance unit, the SSN will be used only to verify income and/or resources through computer matches as listed below or other contacts so that eligibility can be determined for those requesting assistance. If the SSN is not provided, the assistance unit must assume responsibility for providing the information needed to determine eligibility for the individuals requesting assistance. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible participants. For Food Stamp benefits, SSNs may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a household has a Food Stamp benefit overpayment, the information on this application, including the SSNs, may be referred to federal and state agencies as well as private collection agencies for overpayment collection action. The SSN of each person in the assistance unit who provides his/her SSN will be computer matched with the following programs to assist in the determination of eligibility:

- Vital Statistics (Birth & Death)
  –DHHS
- Unemployment Compensation
  –Nebraska Department of Labor
- Employment
  –Nebraska Department of Labor
  –Social Security Administration
  –DHHS
- Child Support
  –Clerk of the District Court
  –Child Support Payment Center
- Resources and Income
  –Internal Revenue Service
- Social Security Benefits (RSDI)
- Supplemental Security Income (SSI)

- Veterans' Benefits
  –Veterans' Administration

The information received from these agencies is used and verified and could affect the kind and amount of assistance individuals receive. SSNs are also used in computer matching and program reviews or audits to make sure each household gets the correct amount of benefits. This may result in criminal or civil action or administrative claims against persons fraudulently participating.

Child Care Assistance, Social Services for the Aged and Disabled (SSAD) and Social Services for Children and Families (SSCF): An SSN is not required to apply for these programs and eligibility will not be denied if SSNs are not provided. If an SSN is provided, it will be used to assemble research data sets that do not identify individuals and to verify income.

MEDICAID

Third Party Liability: Individuals who receive Medical Assistance (Medicaid) assign to the Department of Health and Human Services (DHHS) their right to any medical support or other payment for medical care, agree to cooperate with the DHHS in establishing paternity, and cooperate with the DHHS in obtaining any available third party such as an insurance payment or court settlement. Medicare benefits are not assigned.

Individuals must cooperate with the DHHS in obtaining reimbursement for the cost of medical care and services for any members of the assistance unit. Refusal to cooperate will result in the termination of medical assistance eligibility for that individual. The DHHS will waive the requirement to cooperate if it determines that the individual has good cause for refusing to cooperate. Good cause is a finding by the DHHS that cooperation is against the best interests of the child or against the best interests of the individual because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm, to the individual or other person.

Medical Records Release: Upon release, any person who has medical records and information or the custody of such records regarding Medicaid recipients must release them to the DHHS.

Medical Reimbursement Agreement: When the DHHS pays for services for a Medicaid recipient, the amount the DHHS has paid to treat the injury or illness must be included in any legal claim made against a third party. If the Medicaid recipient later receives an insurance or court settlement, the DHHS must be notified of the settlement and repaid from the settlement for the medical assistance the DHHS has previously paid.

Medicaid:

- Present proof of your current Medicaid eligibility to medical providers before obtaining services.
- Ask your medical provider or worker about which services are covered.
- Inform your worker and your medical providers of any health insurance coverage you have (including dental coverage.)
- Agree to enroll in employer-based group health insurance if the DHHS determines it is cost effective.
- Agree to comply with managed care requirements.
- Pay the cost of all non-covered medical expenses.
- If you get any bills or statements from providers or collection agencies, you are responsible to tell them right away your coverage is Nebraska Medicaid.

Failure to follow certain conditions may result in your being responsible to pay the bills.

Annuity Requirement As a condition of receiving medical assistance coverage for long term care services for you or your spouse, the DHHS must become the remainder beneficiary of any annuity under standards prescribed by the U.S. Secretary of Health and Human Services.

Medicaid Estate Recovery Program: Under Federal law (Social Security Act, Titile 19, Sec. 1917 {42 U.S.C. 1396P}) and State law (Nebraska Rev. Stat. 68-919), the Medicaid Estate Recovery Program authorizes the DHHS to make recovery from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program (471 NAC 38-000). For further information or questions about the Medicaid Estate Recovery Programs, you should contact your DHHS worker and request the "Medicaid Estate Recovery" program brochure.

CHILD SUPPORT ENFORCEMENT (CSE)
1-877-631-9973

The CSE Program is separate from the Public Assistance Program, but your cooperation with CSE is required in order for you to receive public assistance.

Upon approval of your Application for Assistance, your case will be referred from your DHHS Social Service (Public Assistance) worker to the CSE Office. Upon receipt of the referral, the CSE office will mail you a document that outlines your Rights and Responsibilities as they apply to the Nebraska CSE Program.

CHILD SUPPORT ENFORCEMENT (CSE) YEARLY FEE

The payee of the support order will be charged a $25.00 yearly fee once $500 of support has been disbursed, unless the payee meets one of the exemptions below. When a minimum of $500 has been disbursed, the next collection(s) will be retained by the Nebraska Department of Health and Human Services, and applied towards the $25.00 fee. Once the $25.00 fee has been paid, collection(s) will be sent out. The payor of the support order will be given full credit for any payment received.

Exception to being charged the fee:

- Currently receiving Aid to Dependent Children (ADC) and/or Temporary Assistance to Needy Families (TANF);
- Previously received ADC/TANF in Nebraska and/or another state;
- CSE IV-D case(s) which include child(ren) who are currently and/or previously received IV-E foster care services; or
- Fee was assessed and collected in another state during current Federal Fiscal Year.

I understand that it is my responsibility to notify the CSE office if my case qualifies as an exception as listed above.

WORK REQUIREMENTS

Aid to Dependent Children (ADC)/Employment First (EF) Work Requirements If you receive ADC cash assistance, you must participate in approved work activities unless you qualify for an exemption. If you do not cooperate with the work requirements, your benefits may be reduced or ended. ADC recipients will be required to develop and sign an individualized Self-Sufficiency Contract that will identify the goals and list the steps necessary to become economically self-sufficient.

Food Stamp Program (FSP) Work Requirements If you receive food stamp benefits and reside in an area of the state served by the Employment and Training (E&T) program, you must participate in the program unless you qualify for an exemption. If you do not participate in the program and you are the Head of Household you will receive a Work Requirement disqualification and your household's food stamp benefits will be ended. If you do not participate in the program and you are not the Head of Household, you will receive a Work Requirement disqualification and your household's food stamp benefits will be reduced.

VOICE RESPONSE UNIT (VRU) 1-800-383-4278
or in Lincoln 402-323-7455

A VRU is an automated answering service that will provide you with information regarding your application and/or benefits. This service is available to you 24 hours a day, 7 days per week accessed by the above toll free number.

The following programs are included in the VRU:

- Food Stamp (FS), Aid to Dependent Children (ADC), Child Care (CC), Medicaid Eligibility and Aid to Aged, Blind, Disabled (AABD).

The VRU will provide the following information:

- Status of the application (pending or active);
- Amount of benefits authorized/issued;
- Authorized child care dates and fee amount; and if applicable,
- When payment will be mailed.

To inquire about ADC, FS, and/or AABD information, you will need:

- the last four digits of the Social Security number of the Program Case Person (usually the "Program Case Person" is the person who applied; and
- the date of birth of the Program Case Person.

To inquire about Medicaid or CC information, you will need:

- the last four digits of the Social Security number for each person in the household; and
- the date of birth for each person in the household.

You may inquire about the current month, one month previous and the next month. For example: In August, you may inquire about July (previous), August (current) or September (next).

The information on the VRU is available in English and Spanish.

Nebraska Department of Health and Human Services

Notice of Information Privacy Practices

This notice describes how medical information about you may be used and disclosedand how you may access this information. Please review it carefully. *Effective:04/14/2003*

The Department of Health and Human Services of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:

DHHS may access, use and share medical information for purposes of :

- **Treatment:** We may use your medical information to provide you with medical treatment or services. For Example; a doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for medical operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT:

- **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information to a person or company as required by the Food and Drug Administration.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

OTHER USES OF MEDICAL INFORMATION

You can provide us written authorization to use your medical information for other purposes, you may revoke that permission, in writing, at any time.

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.

Nebraska Department of Health and Human Services

DHHS, HIPAA Privacy and Security Office, 301 Centennial Mall South, 5th Floor, P.O. Box 95026, Lincoln, NE 68509-5026

YOUR RIGHTS TO PRIVACY:

❖ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call **(402) 471-8417.**

❖ **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office**.** In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for DHHS;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

❖ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office address on the top of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper, or by e-mail..

❖ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

❖ **We are not required to agree to your request for restrictions.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office at the address on the top of this Notice. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply; for example, disclosures to your spouse.

❖ **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy and Security Office. Your request must specify how or where you wish to be contacted.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with **DHHS** or with the **Secretary of the U.S. Department of Health and Human Services**. To file a complaint with DHHS, you may contact our Privacy Contact, **DHHS HIPAA Privacy and Security Office** at **(402) 471-8417** Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or hipaa.office@dhhs.ne.gov for further information about the complaint process. To file a complaint with HHS, contact: **Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748), 1-866-778-4989-TTY. You will not be penalized for filing a complaint.**

Changes to the Notice of Information Practices

The State of Nebraska Department of Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice. DHHS will provide notice of any material change in revision of these policies.

Contact Information

This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at the State of Nebraska, Department of Health and Human Services please direct them to: The HIPAA Privacy and Security Office, 301 Centennial Mall South, Lincoln, Nebraska 68509-5026. By e-mail to hipaa.office@dhhs.ne.gov.

THIS NOTICE IS AVAILABLE IN LARGER PRINT AND WITH DETAILED EXPLANATION UPON REQUEST.